DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/30/13

PRINTED: 10/23/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	10/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During annual recertification survey and complaint investigations (#32560, #32565, #32598, # 30805), conducted on October 14, 2013, through October 16, 2013, at The Bridge of Monteagle, no deficiencies were cited in relation to the complaints under 42 CFR PART 483, Requirements for Long Term Care.	F 000	Disclaimer: The Bridge at Monteagle does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to ensure staff provided at least two bathing opportunities per week for one resident (#1) of thirty-nine residents reviewed. The findings included: Resident # 1 was admitted to the facility on October 6, 2013, with diagnoses of Dementia, Depression, Flaccid Hemiplegia and Hemiparesis; Chronic Airway Obstruction, Essential Hypertension, Osteoporosis, and Esophageal Reflux. Interview with the resident on October14, 2013 in the resident's room at 2:15 p.m., revealed the	F 246	F246 Reasonable Accommodation of Needs/Preferences A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except with the health or safety of the individual or other residents would be endangered.	11/15/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 resident had no choice of how many times per week a bath or shower was given. Continued interview revealed the resident had only one bath each week for the last two weeks and wanted one today. Interview revealed the resident preferred to have showers. Medical record review of the facility "Bathing Report" confirmed the resident had only one bath per week for the last three weeks. Further review of the Bathing Report revealed on September 27, 2013 the resident received a partial bed bath, on October 7, 2013 a full bath and on October 14, 2013 a shower. Review of the facility policy " Subject : Shower; Department Clinical with an effective date of 12-2010; Guideline: The residents will be provided/ offered a shower, as appropriate, at least two (2) times per week according to established shower schedule. Additional showers may be given as necessary to keep a resident clean and odor free. Residents will be provided/ offered a bed bath if resident refuses or is clinically unable to participate with the shower..." Interview with Registered Nurse (RN) #2, on October 14,2013 at 2:44 p.m., at the East hall Nurses' station, confirmed the resident had not received an acceptable number of baths per facility policy.	F 246	**Residents affected:** Resident #1 received a shower on 10/14/13 by CNAs. Resident was assessed on 10/16/13 by the Social Services Director to determine the resident's preference for bathing and days and times to be bathed. The resident's shower schedule was updated on 10/16/13 by the Unit Manager to reflect the resident's bathing preference and at least two bathing opportunities per week. **Residents potentially affected:** All residents have the potential to be affected by this cited practice regarding bathing and receiving at least two bathing opportunities per week. Unit managers will assess all residents to determine each resident's preference for bathing as well as days and times to be bathed by 11/8/13. All residents' bathing schedules will be updated by the DON/Unit Managers to reflect each resident's preference for bathing and that each resident is scheduled at least two bathing opportunities per week by 11/15/13. **Systemic measures:** Unit managers will educate staff regarding facility bathing policy and updated bathing schedule by 11/15/13. Unit managers will monitor compliance with resident shower schedule daily and report findings during daily stand down meeting. **Monitoring Measures:** Wound care nurse to audit residents' bathing records twice weekly to determine compliance with two bathing opportunities per week. Wound care nurse will notify unit manager and DON if a resident misses a single bathing opportunity so that resident can be offered an additional bathing opportunity. Any issues identified regarding this cited practice will be addressed monthly in QA x 2 months for recommendations and further follow up as indicated.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280		

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F 280	Continued From page 2 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan to reflect the changing needs of the residents for one (#70) and failed to revise the care plan after a fall for one (#15) of thirty-nine residents reviewed.. The findings included: Resident #70 was admitted to the facility on July 14, 2010, with diagnoses including Diabetes, Psychosis, Dysphagia, Seizures, Hypertension, Schizophrenia; and Quadriplegia. Medical record review of the weekly nursing summary dated October 12, 2013, revealed the resident had memory problems; was severely impaired cognitively; could be loud and disruptive;	F 280	F280 **Right to Participate Planning Care-Revise CP** The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment, **Residents affected:** The care plan for resident # 70 was updated on 10/15/13 by the Wound Care Nurse to include an air mattress, wedge when turned, and specifics of wound care. The care plan for resident #15 was updated on 10/16/13 by the Unit Manager to reflect the fall intervention to attempt to a clutter free environment in the resident's room. **Residents potentially affected:** All residents have the potential to be affected by this cited practice regarding care plans not being revised to reflect the changing needs of the resident. All resident care plans will be reviewed by 11/22/13 by the Unit Managers specifically pertaining to skin problems and falls then revised as needed to reflect the changing needs of the residents. **Systemic measures:** The DON/Unit Managers will educate nursing staff on accuracy of care plans related to skin problems and fall interventions by 11/22/13. Nursing staff will update care plans with appropriate interventions for new skin problems identified and new falls as they occur. **Monitoring Measures:** Care plans for new skin problems and falls will be reviewed for accuracy during clinical meeting throughout the week and revised as needed to reflect the changing needs of the resident. Any issues identified regarding this cited practice will be addressed monthly in QA x 2 months for recommendations and further follow up as indicated.	11/22/13

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F 280	Continued From page 3 was total dependence with bathing, dressing, and grooming, transfers, and bed mobility; was always incontinent of bowel and bladder; and had a Stage IV pressure ulcer. Medical record review of the resident's Braden Scale (used to measure risk of skin breakdown) dated June 18, 2013,and September 9. 2013, indicated a score of 13 both months for a moderate risk of skin breakdown. Medical record review of skin assessments revealed no issues with skin during July 2013. Continued review of skin assesement dated August 4, 2013, revealed "...stage II gluteal cleft (buttocks) measuring 1 x 0.3 x 0.1 centimeters with wound margins and surrounding tissue intact. Medical record review of the Pressure Ulcer Record dated September 25, 2013, revealed the resident was to have a wedge cushion behind the back when turned to keep pressure off the ulcerated area. Medical record review of the care plan dated June 28, 2013, revealed the potential for developing skin breakdown as a problem with the addition on August 2, 2013, of a stage II pressure ulcer gluteal cleft. Continued review of the care plan revealed no documentation of specific care for the pressure ulcer. Further review of the care plan revealed no documentation the resident was to have a wedge behind the back when turned to keep pressure off the ulcer. Interview with the Wound Care Nurse on October 16, 2013, at 2:45 p.m., in the office of the Director of Nursing, revealed the resident's ulcer was	F 280		

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F 280	Continued From page 4 measured this morning and was 4.5 x 2 x 0.1 and the physician reordered Santyl for another 14 days. Continued interview with the Wound Care Nurse confirmed the care plan was updated last night (October 15, 2013) to include the air mattress; wedge when turned; and specifics of ulcer care. Further interview with the Wound Care Nurse confirmed prior to the evening of October 15, 2013, the use of the wedge and specifics of wound care had not been included in the care plan. Resident #15 was admitted to the facility on August 8, 2012, with diagnosis including Dementia with Behaviors, Alzheimer's Disease, Osteoporosis, and Cardiac Murmurs. Medical record review of the annual Minimum Data Set, (MDS) dated July 17, 2013, revealed the resident scored a three on the Brief Interview for Mental Status (BIMS) indicating the resident was severely cognitively impaired, required limited assistance with activities of daily living and had a history of falls. Medical record review of the resident's care plan, dated July 25, 2013, revealed "...at risk for fall related injury...ambulates behind w/c (wheelchair), also has walker available for use...is non-compliant at times with safety interventions..." Continued medical record review revealed no documentation of the October 11, 2013 fall or interventions related to this fall. Observation on October 16, 2013, at 7:25 a.m., in the resident's room, revealed the resident laying on the bed, asleep, a wheel chair in the room and the resident's call light within reach.	F 280		

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F 280	Continued From page 5 Interview with the West Wing Unit Manager, on October 16, 2013, at 11:20 a.m., in the nurses' station, confirmed "...resident did have a fall on October 11, 2013...came out of the room and tripped over another resident's wheelchair...we did a teachable moment with the staff regarding "...always attempt to keep a clutter free environment for resident..." Continued interview confirmed "...interventions are started immediately after the incident...the care plan is updated by the unit manager regarding the interventions each morning and we did not update the resident's care plan after the fall..."	F 280		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	F441 Infection Control, Prevent Spread, Linens The facility must establish an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a)Infection Control Program The facility must establish an Infection Control Program under which it – (1)Investigates, controls, and prevents infections in the facility; (2)Decides what procedures, such as isolation, should be applied to an individual resident; and (3)Maintains a record of incidents and corrective actions to infections. (b)Preventing Spread of Infection (1)When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	11/29/13

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F 441	Continued From page 6 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to ensure staff followed infection control practices for oxygen treatments, hand washing, and sanitation of multi-resident use equipment. The findings included: Resident # 105 was admitted to the facility on January 13, 2011, with diagnoses of Alzheimer's disease, Dementia without Behavioral Disturbance, Depressive Disorder, Psychosis, Irritable Bowel Syndrome, and Senile Delusion. During the initial tour on October 14, 2013, at 10:30 a.m., on the West hall, observation of resident #105, in the resident's room revealed a nasal cannula in use, with a date of September 22, 2013. Review of facility policy "Departmental (Respiratory Therapy) - Prevention of Infection	F 441	(2)The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3)The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c)Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. **Residents affected:** The nasal cannula for resident # 105 was replaced by the DON on 10/14/13 and dated to reflect that date. CNA #1 along with all staff were educated regarding proper hand washing on 10/25/13 by the East Unit Manager. The "Silent Knight" pill crushers were thoroughly cleaned on 10/16/13 by the Unit Managers. Staff were educated by the east unit manager on 10/25/13 regarding cleaning the "Silent Knight" pill crushers each shift by Charge Nurses. **Residents potentially affected:** All residents have the potential to be affected by the cited practice regarding infection control. All nasal cannulas were inspected on 10/14/13 and replaced as needed and dated accordingly by Unit Managers. All staff were educated regarding proper hand washing on 10/25/13 by the East Unit Manager. All "Silent Knight" pill crushers were thoroughly cleaned on 10/16/13 by Unit Managers and a cleaning schedule was initiated for all shifts on 10/25/13 by Unit Managers.	

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F 441	Continued From page 7 level I, revised August 2012, stated ...7) Change the oxygen cannulae and tubing every seven (7) days, or as needed..." Interview with Licensed Practical Nurse (LPN) #6, in the resident's room on October 14, 3013 at 10:35 a.m., confirmed the tubing was dated September 22, 2013 and had not been changed in fifteen days Observation on October 14, 2013 at 12:35 p.m. revealed twelve residents in the west dining room. Further observation revealed Certified Nurse Aide (CNA) #1 was serving trays to the residents. Further observation revealed one resident requested help placing the feet on the floor from the wheelchair supports and readjusting the legs. Continued observation revealed CNA #1 went to the resident to assist with the feet and legs. Continued observation revealed CNA #1 went back to delivering trays to the other residents without washing the hands. Further observation revealed CNA #1 went to the resident a second time to readjust the feet and legs. Continued observation revealed CNA #1 did not wash the hands for the second time. Observation on October 14, 2013, at 12:40 p.m., in the west dining room, revealed CNA #2 entered the dining room from the outside courtyard and without washing the hands went to the food delivery cart to pull a lunch tray for a hall delivery. Interview with CNA #1 and CNA #2 October 14, 2013, at 12:45 p.m., at the food delivery cart in the hallway outside the west dining room, confirmed CNA #1 did not wash hands after two physical contacts with residents before passing the lunch trays. Further interview with CNA #2	F 441	**Systemic measures:** Nasal cannulas will be replaced weekly by the resident's Charge Nurse and audited weekly by the Unit Managers. The SDC /DON will complete a competency on all staff regarding proper hand washing by 11/29/13. Charge Nurses will clean "Silent Knight" pill crushers every shift and audited twice weekly by the Restorative Nurse/Unit Managers. **Monitoring Measures:** Unit managers/restorative nurse/designee will report concerns identified with infection control throughout the week in clinical meeting. Infection control issues identified will be addressed monthly in QA x 2 months for recommendations and further follow-up as indicated.	

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F 441	Continued From page 8 confirmed the CNA did not wash hands when entered the dining room from outside and prior to passing the trays to the hall residents. Observation and interview on October 14, 2013, at 3:01 p.m., at the west central medication cart revealed the "Silent Knight" pill crusher had white powdery residue present. Interview with Licensed Practical Nurse (LPN) #7 confirmed the multi-patient use pill crusher was dirty and was in need of cleaning. Observation and interview on October 15, 2013, at 3:29 p.m., at the west medication cart revealed the "Silent Knight" pill crusher had white powdery residue present. Interview with Registered Nurse (RN) #1 confirmed the multi-patient use pill crusher was dirty and was in need of cleaning. Observation and interview on October 16, 2013, at 9:07 a.m., at the east medication cart revealed the "Silent Knight" pill crusher had white powdery residue present. Interview with LPN #4 confirmed the multi-patient use pill crusher was dirty and was in need of cleaning.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain resident care equipment in a sanitary manner.	F 456	**F456 Essential Equipment, Safe Operating Condition** The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. **Residents affected:** The concentrator filters for residents #91 and #40 were cleaned immediately upon identification of the issue. The over bed table supports and legs for residents # 143 and # 92 and the intravenous pole stand for resident #92 was cleaned immediately upon identification of the issue.	10/15/13

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F 456	Continued From page 9 The findings included: Observation and interview with Licensed Practical Nurse #2 confirmed, on October 14, 2013, at 11:44 a.m., of resident #91 with a nasal cannula in place and oxygen set at 2 liters per minute, the two oxygen concentrator filters were white with debris. Further interview revealed the weekend shift was assigned to clean the filters. Observation and interview with Registered Nurse #1 confirmed, on October 15, 2013, at 7:49 a.m., of resident #40 with a nasal cannula in place and oxygen set at 2 liters per minute, the two oxygen concentrator filters were white with debris. Further interview revealed the weekend shift was assigned to clean the filters. Observation and interview with Licensed Practical Nurse #1 confirmed, on October 15, 2013, at 9:35 a.m., in the room of resident #143, the over bed table support and legs had blackened debris and rust present. Further observation and interview confirmed the resident's roommate's over bed table legs had a white powdery residue present. Observation and interview with Licensed Practical Nurse #1 confirmed, on October 15, 2013, at 9:42 a.m., in the room of resident #92, the over bed table support and legs had blackened debris and rust present. Further observation and interview confirmed the intravenous pole stand used by the resident's roommate had dried blackened debris present.	F 456	**Residents potentially affected:** All residents have the potential to be affected by the cited practice regarding clean oxygen concentrator filters, clean over bed table supports and legs, and clean intravenous pole stands. All oxygen concentrator filters, over bed table supports and legs, and intravenous pole stands were inspected and cleaned as needed on 10/15/13 by the Central Supply Manager and the Housekeeping Director and Housekeepers. **Systemic measures:** Central Supply Manager will clean oxygen concentrator filters weekly. Housekeepers will inspect over bed table supports and legs, and intravenous pole stands daily and clean as needed. Nursing staff will clean over bed table supports and legs, and intravenous pole stands as needed. **Monitoring Measures:** Unit managers will audit oxygen concentrator filters weekly. Housekeeping Director will audit over bed table supports and legs, and intravenous pole stands weekly for proper cleaning. Any issues identified regarding this cited practice will be addressed monthly in QA x 2 months for recommendations and further follow-up as indicated.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	10/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SEGOND STREET MONTEAGLE, TN 37356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 10 The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the medical record was accurate and complete for three residents (#63, #85, #68) of thirty-nine residents reviewed. The findings included: Resident #63 was admitted to the facility on April 25, 2013, and readmitted on August 24, 2013, with diagnoses including Advanced Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Peripheral Vascular Disease, and Hyperparathyroidism. Medical record review revealed the resident was transferred from the facility to an acute care facility on August 17, 2013; readmitted to the facility on August 24, 2013; and readmitted to the hospital on August 24, 2013, after which the resident was discharged home with hospice. Medical record review of the undated facility	F 514	**F514 Res Records-Complete/Accurate/accessible** The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. **Residents affected:** The Discharge Assessment and Summary for resident #63 was updated by the IDT team on 10/30/13 to accurately reflect the actual discharge status of the resident. MARs for residents #85 and #68 were corrected by the Unit Manager/Charge Nurse on 10/25/13 to reflect the accurate percentage of medication accepted by the resident. A med error report was completed for both med errors, the physician and POA were notified of the med errors, and the nurse was educated regarding proper MAR documentation and physician notification on 10/29/13 by the DON. **Residents potentially affected:** All charts of discharged residents have the potential to be affected by the cited practice regarding updated and accurate Discharge Assessment and Summary forms. Charts of all residents discharged within the last ninety days were audited for accuracy and completeness on 11/1/13 by Medical Records Director. All residents receiving medications in liquid form have the potential to be affected by the cited practice regarding accurate MAR documentation for medications in liquid form. A med pass competency was completed for all licensed staff, and all licensed staff were educated regarding proper MAR documentation and physician notification on 10/29/13 by the DON.	11/1/13

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BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

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F 514	Continued From page 11 Discharge Assessment and Summary revealed the resident was discharged to the hospital, via ambulatory, accompanied by EMS (Emergency Management System). Continued review of the discharge form revealed the front of the form which included medically defined conditions and prior medical history, summary of diagnoses and conditions at time of discharge, as well as physical/mental status, physical impairments, nutritional status, special treatments, mental and status, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy, was blank. Medical record review of the dietary discharge summary dated September 10, 2013, revealed "...D/cd (discharged) to hospital then passed away..." Medical record review of the undated Activity discharge summary revealed "...was discharged to hospital on August 17, 2013 and later passed away. Medical record review of the undated Social Services discharge summary revealed "...resident was D/C to hospital on August 17, 2013, D/T (due to) illness then D/C to home from hospital..." Medical record review of the undated Nursing discharge summary revealed "...resident was discharged to the hospital for an acute illness. Resident then discharged home from hospital..." Interview with the Director of Nursing (DON) on October 16, 2013, at 2:40 p.m., in the DON's office, confirmed the resident was admitted to the hospital on August 17, 2013, and readmitted to the facility on August 24, 2013. Continued	F 514	**Systemic measures:** Discharge Assessment and Summary form to be initiated by the resident's charge nurse. The unit manager will bring the initiated Discharge Assessment and Summary form to the clinical meeting for completion by the IDT team. The unit manager will verify the accuracy and completeness of the Discharge Assessment and Summary form. A medication pass competency was completed for all licensed staff, and all licensed staff were educated regarding proper MAR documentation and physician notification on 10/29/13 by the DON. The SDC/designee will perform a medication pass with two licensed nurses per month with residents receiving medication in liquid form to ensure proper MAR documentation and physician notification if required. Any areas identified during the medication pass will be immediately corrected with the licensed nurse and education provided by the SDC/DON. **Monitoring Measures:** The Medical Records Director will audit Discharge Assessment and Summary forms for all discharged residents as discharges occur. The Medical Records Director will report concerns identified regarding the Discharge Assessment and Summary form in the clinical meeting and to the administrator throughout the week. The SDC will report concerns identified with medication pass and physician notification in the clinical meeting and to the administrator throughout the week. Above concerns identified will be addressed in QA monthly x 2 months for recommendations and further follow-up as indicated.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	25 SECOND STREET MONTEAGLE, TN 37356

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F 514	Continued From page 12 interview with the DON confirmed the resident became ill; was transferred back to the hospital on August 24, 2013; and was subsequently transferred to home with hospice services. Further interview with the DON confirmed the Discharge Assessment and Summary was not complete and also had conflicting information. Observation and interview on October 14, 2013, at 11:53 a.m., revealed Lactulose (laxative) was ordered for resident #85. Licensed Practical Nurse (LPN) #1 poured the medication without measuring, stated it was 110 milliliters (mls), took the medication to the room and handed the cup to the resident. Continued observation revealed the resident took a sip and sat the cup on the overbed table along with the cup of water provided for other oral medications. Continued observation revealed LPN #1 asked the resident if wanted anymore water or the lactulose, the resident stated no. Further observation revealed LPN #1 took the water and the lactulose and poured them down the sink. Interview with LPN #1 revealed "probably took about one-fourth of the lactulose". Medical record review of the Medication Administration Record (MAR) for October 14 ,2013, revealed documentation the lactulose was administered as ordered. Interview with the Nurse Practitioner (NP), in the NP office, on October 16, 2013, at 10:15 a.m., revealed "...usually the nurses tell me if a resident refuses their medications..." Further interview confirmed the NP would not be notified if a resident doesn't take all of the medications such as lactulose. .	F 514		

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F 514	Continued From page 13 Observation of the medication pass on October 16, 2013, at 8:56 a.m., on resident #68 revealed Miralax (laxative) 17 gms (grams) mixed with 90 mls of Med Pass (nutritional supplement). Further observation revealed LPN #5 handed the medication to the resident and the resident held it without drinking it. Continued observation revealed LPN #5 waited several minutes and the resident took one sip of the medication. Continued observation revealed LPN #5 waited several more minutes and asked the resident if wanted anymore of the "drink" and the resident said no. Continued observation revealed LPN #5 took the medication and discarded it. Medical record review of the MAR at 11:00 a.m., on October 16 ,2013, revealed both medications were marked as administered, and Med Pass was marked as given without a percentage of intake documented.	F 514		